HEALTHY FAMILIES MEDI-CAL FOR FAMILIES
For Your Family's Health

Authorized Representative Form

From: _____

I wish to designate _____
Name of Individual

_____
Organization and Organization Address

to act on my behalf regarding the application for and/or participation in a Healthy Families Program (HFP)/Medi-Cal (MC) Programs.

- **I have completed the "Permission to share information" section of this form which so authorizes the HFP/MC Programs to speak with the individual I have designated above.**
- **I have signed and dated this authorization form below.**
- **I understand that the HFP/MC Programs cannot speak with the individual I have designated above (my authorized representative) until it receives this signed authorization form from me.**

Permission to share information:
I authorize the HFP/MC Programs to speak to the individual designated above who I wish to act on my behalf regarding the application for participation in a HFP/MC Program. I understand that this permission to act on my behalf ends on the date the Program mails me its decision regarding the application.

Applicant's Name: (if different from above) _____
Please Print

Child's Name: _____

Family Member Number: _____

Signature: _____ **Date:** _____

Mail this form to:

Healthy Families/Medi-Cal Programs
Attention: Authorized Representative
P.O. Box 138005
Sacramento, CA 95813-8005

Or, you can fax to: **1-866-848-4974.** The fax number is free.

If you have questions, please call 1-866-848-9166, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday, 8 a.m. to 5 p.m. The call is free.